STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00455009. Complaint IN00455009 - No deficiencies related to the allegations are cited. Survey dates: March 11 & 12, 2025 Facility number: 014213 Residential Census: 123 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed March 19, 2025.	R 0000		
R 0051 Bldg. 00	410 IAC 16.2-5-1.2(u) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to ensure residents were free of chemical restraints used for staff convenience for 3 of 3 residents reviewed for chemical restraint use (Residents 67, 32, and 101). Findings include: During an observation on 3/12/25 at 2:34 p.m., Residents 67, 32 and 101 were seated in the lounge on the secured dementia unit listening to a performance of music and singing. 1. Resident 67's clinical record was reviewed on 3/12/25 at 1:56 p.m. Current diagnoses included major depressive disorder and unspecified	R 0051	Plan of Correction 04/03/2025 Facility ID: 014213 Survey Event ID: V4MK11 R051 **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and**	04/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	dementia, unspecified severity, other behavioral disturbance . The resident had a current physician's order for ABH gel (compound medication consisting of lorazepam [an antianxiety medication], diphenhydramine [an antihistamine medication] and haloperidol [an antipsychotic medication]) apply topically to wrist 3 times daily, ordered 2/24/25. Resident "Notes" were reviewed for 12/1/24 to 3/12/25 and indicated the following: On 1/21/15 at 1:58 p.m., the resident was disruptive during activities and "bossing" other residents. She hit the Activity Director when she attempted to redirect her. On 1/22/25 at 11:48 a.m., the resident was resistant to care. On 1/22/25 at 2:40 p.m., the resident resisted care. On 1/27/25 at 10:57 a.m., the resident wandered behind the nurses station. The nurse called the responsible party to see if they had received the ABH gel. On 2/5/25 at 3:04 p.m., the resident resisted incontinence care. On 2/6/25 at 1:28 p.m., the resident resisted incontinence care. The resident displayed intrusive wandering on 2/24/25 at 1:31 p.m. when she wanted to sit at the nurse's station with staff and became agitated when they moved her away.		**what corrective action will be taken;** a 3 of 3 residents that received a prescription for medications considered to have chemical restraint capabilities, had the potential to be affected by the alleged deficient practice. DON and/or designee will work with the prescribing physician to ensure any resident prescribed medications of this nature, will have a proper corresponding diagnosis. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** a DON and/or designee will work with the prescribing physician to ensure that any resident receiving prescribed medications of this nature, will have a proper corresponding diagnosis. Any clinical staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff,	

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	On 3/5/25 at 11:24 p.m., the resident resisted getting ready for bed, "declined assistance," and would not stand. The resident swung and kicked at staff. Although the resident was refusing care, two staff put her into her bed. Review of "Psychiatric routine follow up Notes" from 3/3/25 to 1/6/25 indicated the following: On 1/23/25, the resident presented as calm and cooperative during this visit. On 2/24/25, the resident was sitting calmly. She did not display any inappropriate behaviors. She appeared to be tired. Staff report she was anxious and agitated with noises. The note lacked indication as to the reason the resident's medication was increased from 2 times daily to 3 times daily on this date. The note lacked justification for the use of an antipsychotic medication. On 3/3/25, the note indicated the resident was previously prescribed ABH gel, apply to wrist 2 times daily for anxiety/agitation approximately 4 weeks prior. The center documents reported she took her medication. During the visit, she displayed appropriate behaviors. She was calm and pleasant during the visit. Continue ABH gel at 3 times daily. 2. Resident 32's clinical record was reviewed on 3/12/25 at 1:42 p.m.. Diagnoses included unspecified dementia and adjustment disorder. The resident had a current physician's order for the for ABH gel apply topically to wrist 2 times daily, ordered 2/12/25.		on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a This process will be reviewed by ED/DON or designee as it occurs. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5 By what date the systemic changes will be completed;** a April 4, 2025 **Informal Dispute Resolution:** Based on the information below, we respectfully request the removal of “offense” tag R 051 410 IAC 16.2-5-1.2 (u) Resident Rights – Offense -According to regulation 410 Ind.Admin.Code IAC 16.2-5-1.2 – Resident Rights (b) Residents have the right to a dignified existence,	

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	Review of Resident "Notes" for 1/27/25 to 3/12/25 indicated the following: On 1/29/25 at 2:53 p.m., the resident refused care and instead wanted to do the task herself. On 1/30/25 at 1:00 p.m., the resident was wandering. On 1/31/25 at 9:46 a.m., the resident was wandering and exit seeking. On 2/8/25 at 2:34 p.m., the resident was exit seeking. On 2/20/25 at 2:22 p.m., the resident resisted care during a shower. She also wanted to dress herself. The resident completed the task on her own. On 2/24/25 at 7:09 a.m., the resident was awake and walking in the halls during the night. On 3/8/25 at 8:29 a.m., the resident refused assistance with peri-care. Review of "Psychiatric routine follow up Notes" from 3/10/25 to 2/3/25 indicated the following: On 2/3/25, the resident did not receive any psychotropic medications at this time. On 2/24/25, the resident has continued to exit seek. The resident was anxious and did not sleep at times. The note lacked indication as to the reason the ABH was ordered on this date. The note lacked justification for the use of an antipsychotic medication.		self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. (c) Residents have the right to exercise any or all of the enumerated rights without: (1) restraint; (2) interference; (3) coercion; (4) discrimination; or (5) threat of reprisal; by the facility. These rights shall not be abrogated or changed in any instance, except that, when the resident has been adjudicated incompetent, the rights devolve to the resident's legal representative. When a resident is found by his or her physician to be medically incapable of understanding or exercising his or her rights, the rights may be exercised by the resident's legal representative. (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident's right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of	

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	On 3/10/25, the nursing staff did not have behavioral concerns at this time. ABH gel was to continue to be applied to wrist 2 times daily for agitation. 3. Resident 101's clinical record was reviewed 3/12/25 at 1:47 p.m. Current diagnoses included adjustment disorder and circadian rhythm sleep disorder. The resident had a current physician's order for the for ABH gel apply topically to wrist 3 times daily, ordered 1/30/25. Review of Resident "Notes" for 12/16/24 to 3/12/25 indicated the following: On 1/11/25 at 1:10 p.m., the resident yelled for help for her family. On 1/18/25 at 9:46 a.m., the resident walked without her assistive device. A 1/19/25 at 7:07 p.m., note indicated "start ABH gel-apply to wrist twice daily for dementia and anxiety." On 1/23/25 at 11:18 p.m., the resident refused assistance to get ready for bed. On 1/28/25 at 3:38 p.m., the resident refused to take her medication. On 1/29/25 at 2:35 p.m., the resident refused to take her medication. On 1/31/25 at 12:56 p.m., the resident refused her medication. On 1/31/25 at 10:49 p.m., the resident refused her		services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. -Per the Statement of Deficiencies: "Based on observation, interview and record review, the facility failed to ensure residents were free of chemical restraints used for staff convenience for 3 of 3 residents reviewed for chemical restraint use." The facility objects to the conclusion on the 2567 statement that **the facility failed to ensure residents were free of chemical restraints used for staff convenience** **Evidence:** The facility has not violated the residents' rights as stated in 410 IAC 16.2-5-1.2(u) because it respects and upholds the residents' right to receive services of their choice by a physician or provider of their choice. Respecting residents' choices is essential to ensuring a dignified existence as it recognizes their autonomy and preferences. This approach promotes a person-centered approach to care, respecting residents' autonomy and dignity. Additionally, please note several non-pharmacological measures, such as distraction, activities and redirection, as well as other pharmacological options were	

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	medication. On 2/1/25 at 11:06 a.m., the resident refused her medication. On 2/3/25 at 1:22 p.m., the resident refused her medications. Review of "Psychiatric routine follow up Notes" from 3/10/25 to 12/16/25 indicated the following: On 1/23/25, nursing staff reported the resident was just treated for a urinary tract infection (UTI). Nursing staff reported the resident became agitated, anxious, didn't sleep at night, and had to be re-directed at times. On 1/27/25, the resident was non-compliant with taking medications. On 2/10/25, the resident was to continue the ABH gel to wrist 2 times daily for anxiety/agitation. The note lacked justification for the use of an antipsychotic medication. During an interview on 3/12/25 at 10:07 a.m., the DON indicated she had expressed her concern regarding a hospice/end of life/terminal restlessness and/or terminal pain medication (the ABH gel) being used to treat residents with dementia and anxiety. During an interview on 3/12/25 at 2:34 p.m., Activity Assistant 2 indicated Resident 67 was sometimes upset or angry and Residents 32 and 101 did not display maladaptive concerns. During an interview on 3/12/25 at 2:36 p.m., CNA 3 indicated sometimes Resident 67 resisted care,		attempted prior to this medication being prescribed. Please see the following supporting documentative that refutes the claim that the residents were subject to “chemical restraints”. Statements from the provider and family, case studies, CMS supporting article, pharmacy recommendations, and notes from the facility, provider and psych provider that all undoubtedly support the benefit of using this specific medication in all 3 resident instances. Attachment A: Family Statements Attachment B: Provider Statements Attachment C: Resident Service Plans Attachment D: Pharmacy Recommendations Attachment E: NP Notes Attachment F: Psych NP Notes Attachment G: Nursing Notes Attachment H: CMS Guidance 410 IAC 16.2-5 is maintained by honoring the residents' right to choose a physician of their choice and following physician orders. By accommodating the residents' and legal representatives’ preferences, the facility is in compliance with this regulation, as it does not restrict their access to services or communication with persons and services both inside and outside the facility. In conclusion, the use of ABH gel	

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	and Residents 101 and 32 did not display maladaptive behaviors. During an interview on 3/12/25 at 2:37 p.m., CNA 4 indicated Resident 67 at times resisted care or redirection. The other 2 residents did not display maladaptive behaviors. A current, 5/2023, facility policy titled "Statement of Resident Rights," provided by the facility following the entrance conference on 3/11/25 indicated the following: "...17. Be free of physical or chemical restraints imposed for the purpose or convenience and not required to treat a resident's medical symptoms...."		proved to be beneficial and enhance the residents quality of life proving the facility has not failed to ensure residents were free of chemical restraints used for staff convenience.	